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104TH CONGRESS
1ST SESSION

H. R. 439

To promote portability of health insurance by limiting discrimination in health coverage based on health status or past claims experience.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 9, 1995

Mr. HAYES (for himself and Mr. MCCRERY) introduced the following bill; which was referred to the Committee on Commerce and, in addition, to the Committee on Economic and Educational Opportunities, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To promote portability of health insurance by limiting discrimination in health coverage based on health status or past claims experience.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Insurance Equity Act of 1995''.

SEC. 2. HEALTH INSURANCE STANDARDS.

The Social Security Act is amended by adding at the end the following new title:

''TITLE XXI—STANDARDS FOR HEALTH COVERAGE

''SEC. 2101. PROHIBITION OF DISCRIMINATION BASED ON HEALTH STATUS FOR COVERAGE, BENEFITS, AND PREMIUMS.

''(a) IN GENERAL.—Except as provided under subsection (b), an insurer or group health plan providing health coverage may not deny, limit, or condition the health coverage or benefits with respect to health services, or vary the premiums charged for such coverage, based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

''(b) EXCEPTION FOR CERTAIN PREEXISTING CONDITIONS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, an insurer or group health plan providing health coverage may exclude coverage of services related to treatment of a preexisting condition, but the period of such exclusion may not exceed 6 months. The exclusion of coverage shall not apply to services furnished to newborns who are covered at the time of birth or to treatment of conditions relating to pregnancy.

''(2) CREDITING OF PREVIOUS COVERAGE.—

''(A) IN GENERAL.—An insurer or group health plan providing health coverage shall provide that if a covered individual is in a period of continuous coverage (as defined in subparagraph (B)(i)) with respect to particular services as of the date of application for coverage (determined without regard to any waiting period for coverage), any period of exclusion of coverage with respect to a preexisting condition for such services or type of services shall be reduced by 1 month for each month in the period of continuous coverage.

''(B) DEFINITIONS.—As used in this subsection:

''(i) PERIOD OF CONTINUOUS COVERAGE.—The term 'period of continuous coverage' means, with respect to particular services, the period beginning on the date an individual has health coverage (including coverage under title XVIII or XIX) which provides substantially the same or similar benefits with respect to such services and ends on the date the individual does not have such coverage for a continuous period of more than 3 months.

''(ii) PREEXISTING CONDITION.—The term 'preexisting condition' means a condition which has been diagnosed or treated during the 6-month period ending on the day before the first date of such coverage.

''(3) EXCEPTION.—

''(A) IN GENERAL.—Subsection (a) shall not affect a variation of premiums based only on the age, sex, or geographic area of residence of an individual.

''(B) WAITING PERIOD.—An insurer or group health plan providing health coverage may offer to an individual to waive an exclusion of coverage with respect to a preexisting condition for which an exclusion could otherwise be applied under this subsection in exchange for an increase in the premium during the period in which the exclusion could otherwise be applied. If the individual rejects this offer, the limitations on premiums and exclusions that would apply in the absence of such offer shall continue to apply.

''(c) APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—A health maintenance organization that provides health insurance coverage shall

not be considered as failing to meet the requirements of section 1301 of the Public Health Service Act notwithstanding that it provides for an exclusion of the coverage based on a preexisting condition consistent with the provisions of this section so long as such exclusion is applied consistent with the provisions of this section. Nothing in this section shall be construed as requiring such an organization to impose such an exclusion.

"SEC. 2102. ENROLLMENT AND RENEWAL PRACTICES FOR HEALTH INSURANCE COVERAGE.

''(a) CONSTRUCTION INVOLVING APPLICATION OF CAPACITY LIMITS FOR HEALTH INSURANCE COVERAGE.—

''(1) IN GENERAL.—Subject to paragraph (2) and subsection (b), nothing in this title shall be construed as preventing an insurer providing health insurance coverage to individuals or small employers in an area from ceasing to enroll individuals or small employers under such coverage if—

''(A) the insurer ceases to enroll any new individuals or small employers; and

''(B) the insurer can demonstrate to the State insurance commissioner that the insurer's financial or provider capacity to serve previously covered individuals or small employers

(and additional individuals who will be expected to enroll because of affiliation with such previously covered individuals or small employers) will be impaired if it is required to enroll additional individuals or small employers.

''(2) FIRST-COME-FIRST-SERVED.—An insurer is only eligible to exercise the limitations provided for in paragraph (1) if such insurer provides for enrollment of individuals or small employers on a first-come-first-served basis (except in the case of additional individuals or small employers described in paragraph (1)(B)).

''(b) REQUIREMENTS RELATING TO RENEWAL OF HEALTH INSURANCE COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), an insurer that provides health insurance coverage to an individual or small employer shall not deny, cancel, or refuse to renew such coverage of the individual or small employer.

''(2) GROUNDS FOR REFUSAL TO RENEW.—An insurer may deny, cancel, refuse to renew, or terminate health insurance coverage within a type of coverage option described in paragraph (4) in an area described in paragraph (6) only—

''(A) for nonpayment of premiums;

''(B) for fraud on the part of the individual or small employer;

''(C) with respect to an individual, for misrepresentation of material facts on the part of the individual relating to an application for coverage or claim for benefits;

''(D) in the case of coverage provided through a geographically limited managed care arrangement, the individual or employer leaves the geographic service area in which the coverage is provided; or

''(E) subject to paragraph (3), because the insurer elects not to renew any health insurance coverage for individuals or small employers in the area within such type of coverage option and provides notice of such election to the State insurance commissioner and to each such employer and individual covered in the area at least 180 days before the effective date of such nonrenewal.

''(3) PROHIBITION ON MARKET REENTRY.—In the case of an election described in paragraph (2)(E) by an insurer for an area for a type of coverage option, the insurer may not provide for any health insurance coverage to an individual or small employer

in the area within the type of coverage option during the 5-year period beginning on the effective date of the nonrenewal for the area and for the type of coverage option.

''(4) OPTIONS.—For purposes of this subsection, each of the following is a 'type of coverage option':

''(A) FEE-FOR-SERVICE OPTION.—Health insurance coverage is considered to provide a 'fee-for-service option' if, regardless of whether covered individuals may receive benefits through a provider network, benefits with respect to the covered items and services in the coverage are made available for such items and services provided through any lawful provider of such covered items and services and payment is made to such a provider whether or not there is a contractual arrangement between the provider and the carrier or plan.

''(B) MANAGED CARE OPTION.—Health insurance coverage is considered to provide a 'managed care option' if benefits with respect to the covered items and services in the coverage are made available exclusively through a pro-

vider network, except in the case of emergency services and as otherwise required under law.

''(C) POINT-OF-SERVICE OPTION.—Health insurance coverage is considered to provide a 'point-of-service option' if the benefits with respect to covered items and services in the coverage are made available principally through a managed care arrangement, with the choice of the enrollee to obtain such benefits for items and services provided through any lawful provider of such covered items and services. The coverage may provide for different cost sharing schedules based on whether the items and services are provided through such an arrangement or outside such an arrangement.

''(5) MANAGED CARE ARRANGEMENTS.—In this subsection:

''(A) MANAGED CARE ARRANGEMENT.—The term 'managed care arrangement' means, with respect to health insurance coverage, an arrangement under such coverage under which providers agree to provide items and services covered under the arrangement to individuals who have such coverage.

''(B) PROVIDER NETWORK.—The term 'provider network' means, with respect to health insurance coverage, providers who have entered into an agreement described in subparagraph (A).

''(6) LIMITATIONS ON AREA.—An area described in this paragraph is an area in which there is no division of any of the following:

''(A) A 3-digit zip code.

''(B) Any county, parish, or borough.

''(C) All portions of a metropolitan statistical area.

"SEC. 2103. ENFORCEMENT.

''(a) HEALTH INSURANCE COVERAGE.—

''(1) ENFORCEMENT THROUGH STATE INSURANCE COMMISSIONER.—

''(A) ESTABLISHMENT OF ENFORCEMENT PROGRAMS.—Each State, through its State insurance commissioner, is responsible for establishing a program to enforce requirements of this title with respect to insurers (and health coverage offered by insurers) in the State. The State shall provide the Secretary of Health and Human Services annually (for years beginning with 1996) with such description of the pro-

gram established to enforce adequately such requirements as the Secretary specifies.

''(B) MORE STRINGENT STATE STANDARDS PERMITTED.—A State may implement standards that are more stringent than the standards established under this title.

''(C) AUTHORIZATION OF APPROPRIATIONS FOR STATE ENFORCEMENT PROGRAMS.—There are authorized to be appropriated to the Secretary of Health and Human Services (for each fiscal year beginning with fiscal year 1996) such sums as may be necessary to provide for grants to States to provide for enforcement programs described in subparagraph (A). Such grants shall be made available in such amounts and subject to such reasonable terms and conditions as the Secretary shall provide.

''(2) FEDERAL FALLBACK ENFORCEMENT.—

''(A) REVIEW AND CONTINGENCY.—The Secretary annually shall review State enforcement programs under paragraph (1)(A) to determine if they provide for adequate enforcement of the requirements of this title. If the Secretary initially determines that such a program does not provide for such enforcement,

the Secretary shall notify the State and provide the State an opportunity to adopt such a plan of correction that would provide for adequate enforcement. If the Secretary makes a final determination that the State program fails to provide for an adequate enforcement program after such an opportunity, the succeeding provisions of this paragraph shall apply with respect to insurers and health insurance coverage in the State until the Secretary has been provided a description of an adequate enforcement program.

''(B) CIVIL MONEY PENALTIES.—

''(i) IN GENERAL.—If this paragraph applies in a State in a year, subject to clause (ii), an insurer in that State that fails to comply with a requirement applicable to the insurer or health insurance coverage under this title is subject to a civil money penalty of $150 for each day during which such failure persists for each individual to which such failure relates.

''(ii) LIMITATION.—The amount of the penalty imposed by this subparagraph for an insurer with respect to health insur-

ance coverage shall not exceed 25 percent of the amounts received under the plan for coverage during the period such failure persists.

''(C) EXCEPTIONS.—

''(i) CORRECTIONS WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph by reason of any failure if—

''(I) such failure was due to reasonable cause and not to willful neglect, and

''(II) such failure is corrected within the 30-day period beginning on the earliest date the insurer knew, or exercising reasonable diligence would have known, that such failure existed.

''(ii) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by this paragraph to the extent that payment of such penalty would be excessive relative to the failure involved.

''(D) PROCEDURES.—The Secretary by regulation shall provide for procedures for the imposition of civil money penalties under this paragraph. Such procedures shall assure written notice and opportunity for a determination to be made on the record after a hearing at which the insurer is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the insurer. The provisions of subsections (e), (f), (j), and (k) of section 1128A shall apply to determinations and civil money penalties under this paragraph in the same manner as they apply to determinations and civil money penalties under such section.

''(b) ENFORCEMENT BY DEPARTMENT OF LABOR FOR GROUP HEALTH PLANS.—

''(1) IN GENERAL.—For purposes of part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of sections 2101 and 2102 shall be deemed to be provisions of title I of such Act irrespective of exclusions under section 4(b) of such Act.

''(2) REGULATORY AUTHORITY.—With respect to the regulatory authority of the Secretary of Labor

under this title pursuant to paragraph (1), section 505 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1135) shall apply.

"SEC. 2104. DEFINITIONS.

''For purposes of this title:

''(1) GROUP HEALTH PLAN.—The term 'group health plan' means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise, but does not include any type of coverage excluded from the definition of an health insurance coverage under paragraph (3)(B).

''(2) HEALTH COVERAGE.—The term 'health coverage' means health insurance coverage provided by an insurer or medical care provided under a group health plan.

''(3) HEALTH INSURANCE COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'health insurance coverage' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by an insurer.

''(B) EXCEPTION.—Such term does not include any of the following (or any combination of the following):

''(i) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

''(ii) Medicare supplemental health insurance.

''(iii) Coverage issued as a supplement to liability insurance.

''(iv) Liability insurance, including general liability insurance and automobile liability insurance.

''(v) Workers' compensation or similar insurance.

''(vi) Automobile medical-payment insurance.

''(vii) Coverage for a specified disease or illness.

''(viii) A hospital or fixed indemnity policy.

''(4) INSURER.—The term 'insurer' means a licensed insurance company, an entity offering prepaid hospital or medical services, and a health main-

tenance organization, and includes a similar organization regulated under State law for solvency.

''(5) SMALL EMPLOYER.—The term 'small employer' means, with respect to a calendar year, an employer (as defined in section 3(5) of the Employee Retirement Income Security Act of 1974) that normally employs on a typical business day more than 1 but less than 50 employees who normally perform on a monthly basis at least 30 hours of service per week for that employer. For the purposes of this paragraph, the term 'employee' includes a self-employed individual. For purposes of determining if an employer is a small employer, rules similar to the rules of subsections (b) and (c) of section 414 of the Internal Revenue Code of 1986 shall apply.

''(6) STATE INSURANCE COMMISSIONER.—The term 'State insurance commissioner' includes a State superintendent of insurance or other State authority responsible for regulation of health insurance.''.

SEC. 3. EFFECTIVE DATE.

The requirements of title XXI of the Social Security Act, as added by section 2, shall apply with respect to—

(1) group health plans for plan years beginning after December 31, 1995, and

(2) insurers as of January 1, 1996, for health insurance coverage issued or renewed on or after such date.

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